		FOR OHF USE					

LL1

2005
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2005)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0045617

Facility Name: Lawrence Community Healthcare Center, Inc.

Address: 900 E. Corporation Street (Number) Bridgeport (City) 62417 (Zip Code)

County: Lawrence

Telephone Number: (618) 945-2091 **Fax #** (618) 945-9030

IDPA ID Number: 45617

Date of Initial License for Current Owners: 08/02/96

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: John Knoblett **Telephone Number:** (618) 943-3344

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/05 to 12/31/05 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) William R. Gillis
(Title) Administrator

Paid Preparer

(Signed) _____ (Date)
(Print Name and Title) John Knoblett, CPA, Partner
(Firm Name & Address) Kemper CPA Group LLP, 1100 Lexington Avenue, Lawrenceville, IL 62439
(Telephone) (618) 943-3344 Fax # (618) 943-2368

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lawrence Community Healthcare Center, Inc. # 0045617 Report Period Beginning: 01/01/05 Ending: 12/31/05

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	99	Skilled (SNF)	99	36,135	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	99	TOTALS	99	36,135	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	16,689	8,844	3,047	28,580	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	16,689	8,844	3,047	28,580	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 79.09%

D. How many bed-hold days during this year were paid by the Department?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
Day Care

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 08/02/96

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 08/02/96 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 56 and days of care provided 3,047

Medicare Intermediary Administar Federal, Inc.

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/05 Fiscal Year: 12/31/05

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Facility Name & ID Number Lawrence Community Healthcare Center, In # 0045617 Report Period Beginning: 01/01/05 Ending: 12/31/05

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	160,241	19,675	4,463	184,379		184,379	(7,847)	176,532			1
2	Food Purchase		155,908		155,908		155,908	(239)	155,669			2
3	Housekeeping	133,484	39,870	260	173,614		173,614		173,614			3
4	Laundry	29,047	36,765	100	65,912		65,912		65,912			4
5	Heat and Other Utilities			57,411	57,411		57,411		57,411			5
6	Maintenance	37,876	4,862	66,925	109,663		109,663		109,663			6
7	Other (specify):*											7
8	TOTAL General Services	360,648	257,080	129,159	746,887		746,887	(8,086)	738,801			8
	B. Health Care and Programs											
9	Medical Director			2,000	2,000		2,000		2,000			9
10	Nursing and Medical Records	1,075,871	65,994	30,897	1,172,762	(227,509)	945,253	(3,760)	941,493			10
10a	Therapy			365,949	365,949		365,949		365,949			10a
11	Activities	60,861	1,958	1,542	64,361		64,361		64,361			11
12	Social Services	36,027		1,421	37,448		37,448		37,448			12
13	CNA Training											13
14	Program Transportation			607	607		607		607			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,172,759	67,952	402,416	1,643,127	(227,509)	1,415,618	(3,760)	1,411,858			16
	C. General Administration											
17	Administrative	83,650		265,669	349,319	(116,196)	233,123	(95,123)	138,000			17
18	Directors Fees											18
19	Professional Services			17,957	17,957	2,045	20,002		20,002			19
20	Dues, Fees, Subscriptions & Promotions			9,623	9,623		9,623	(25)	9,598			20
21	Clerical & General Office Expenses	43,037		91,880	134,917	86,402	221,319	(21,513)	199,806			21
22	Employee Benefits & Payroll Taxes			229,946	229,946	14,833	244,779		244,779			22
23	Inservice Training & Education			2,354	2,354		2,354		2,354			23
24	Travel and Seminar			19,141	19,141	2,245	21,386		21,386			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			48,652	48,652	470	49,122		49,122			26
27	Other (specify):*											27
28	TOTAL General Administration	126,687		685,222	811,909	(10,201)	801,708	(116,661)	685,047			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,660,094	325,032	1,216,797	3,201,923	(237,710)	2,964,213	(128,507)	2,835,706			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Lawrence Community Healthcare Center, Inc. #0045617 Report Period Beginning: 01/01/05 Ending: 12/31/05

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			71,441	71,441	28,682	100,123		100,123			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			778	778	56,221	56,999	(2,337)	54,662			32
33	Real Estate Taxes			34,034	34,034		34,034		34,034			33
34	Rent-Facility & Grounds			121,245	121,245	(83,138)	38,107	(38,107)				34
35	Rent-Equipment & Vehicles					7,256	7,256		7,256			35
36	Other (specify):*											36
37	TOTAL Ownership			227,498	227,498	9,021	236,519	(40,444)	196,075			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			142,690	142,690	227,509	370,199		370,199			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			54,203	54,203		54,203		54,203			42
43	Other (specify):* see pg 24			139	139	1,180	1,319	(1,319)				43
44	TOTAL Special Cost Centers			197,032	197,032	228,689	425,721	(1,319)	424,402			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,660,094	325,032	1,641,327	3,626,453		3,626,453	(170,270)	3,456,183			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lawrence Community Healthcare Center, Inc. # 0045617 Report Period Beginning: 01/01/05 Ending: 12/31/05

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$ (3,760)	10	$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(7,847)	1		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(2,337)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(239)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(1,420)	21		16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(1,319)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(19,953)	21		24
25	Fund Raising, Advertising and Promotional	(25)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(1,669)	17		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule see pg 24	(140)	21		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (38,709)		$	30

OHF USE ONLY									
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(131,561)	Var	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (131,561)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (170,270)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Lawrence Community Healthcare Center, Inc.

ID# 0045617

Report Period Beginning: 01/01/05

Ending: 12/31/05

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Miscellaneous income	$ (140)	21	1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(140)		49

STATE OF ILLINOIS **Summary A**

Facility Name & ID Number Lawrence Community Healthcare Center, Inc. **#** 0045617 **Report Period Beginning:** 01/01/05 **Ending:** 12/31/05

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	(7,847)	0	0	0	0	0	0	0	0	0	0	(7,847)	1
2	Food Purchase	(239)	0	0	0	0	0	0	0	0	0	0	(239)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(8,086)	0	0	0	0	0	0	0	0	0	0	(8,086)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(3,760)	0	0	0	0	0	0	0	0	0	0	(3,760)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(3,760)	0	0	0	0	0	0	0	0	0	0	(3,760)	16
	C. General Administration													
17	Administrative	(1,669)	(93,454)	0	0	0	0	0	0	0	0	0	(95,123)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(25)	0	0	0	0	0	0	0	0	0	0	(25)	20
21	Clerical & General Office Expenses	(21,513)	0	0	0	0	0	0	0	0	0	0	(21,513)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(23,207)	(93,454)	0	0	0	0	0	0	0	0	0	(116,661)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(35,053)	(93,454)	0	0	0	0	0	0	0	0	0	(128,507)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number **Lawrence Community Healthcare Center, Inc.** **#** **0045617** **Report Period Beginning:** **01/01/05** **Ending:** **12/31/05**

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(2,337)	0	0	0	0	0	0	0	0	0	0	(2,337)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(38,107)	0	0	0	0	0	0	0	0	0	(38,107)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(2,337)	(38,107)	0	0	0	0	0	0	0	0	0	(40,444)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(1,319)	0	0	0	0	0	0	0	0	0	0	(1,319)	43
44	**TOTAL Special Cost Centers**	(1,319)	0	0	0	0	0	0	0	0	0	0	(1,319)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(38,709)	(131,561)	0	0	0	0	0	0	0	0	0	(170,270)	45

Facility Name & ID Number Lawrence Community Healthcare Center, Inc. # 0045617 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See pg 29						

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	17	Management Fees	$ 264,000	Rincker Healthcare	100.00%	$ 170,546	$ (93,454)	1
2	V	34	Facility Rental	121,245	William F. Rincker Trust		83,138	(38,107)	2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 385,245			$ 253,684	$ * (131,561)	14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number Lawrence Community Healthcare Center, Ir # 0045617 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1	William F. Rincker		Management	20.00	18,339			Wages	$ 11,661	17-1	1
2	Jane Rincker	Accounting Supv.	Bookkeeping	20.00	106,979	10	0.25	Wages	68,021	21-1	2
3	Angela West		Management	20.00	18,339			Wages	11,661	17-1	3
4	Deanna Gillis		Management	20.00	18,339	12.5	0.50	Wages	11,661	17-1	4
5	William R. Gillis	Administrator	Management	20.00	25,675	32.5	0.81	Wages	99,975	17-1	5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 202,979		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Lawrence Community Healthcare Center, Inc. # 0045617 Report Period Beginning: 01/01/05 Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Rincker Healthcare Corporation
Street Address: 900 E. Corporation
City / State / Zip Code: Bridgeport, IL 62417
Phone Number: ((618) 945-2091
Fax Number: ((618) 945-9030

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1		See attached schedule pg 25				$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Lawrence Community Healthcare Center, Inc # 0045617 Report Period Beginning: 01/01/05 Ending: 12/31/05

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	First Financial Bank N.A.		X	Purchase	$8,437.77	08/02/96	$ 1,014,000	$ 804,316	09/15/17	6.5000	$ 53,887	1
2												2
3	First Financial Bank N.A.		X	Purchase - Rincker Healthcare							1,765	3
4	See pg. 25			Amortization of loan cost							569	4
5	Toyota Financial Services		X	Purchase - Van	$342.68	09/14/04	18,203	14,061	09/14/09	4.9000	778	5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				$8,780.45		$ 1,032,203	$ 818,377			$ 56,999	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 1,032,203	$ 818,377			$ 56,999	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** _____ **Line #** _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

SEE ACCOUNTANTS' COMPILATION REPORT

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number Lawrence Community Healthcare Center, Inc. # 0045617 **Report Period Beginning:** 01/01/05 **Ending:** 12/31/05

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2004 report.	***Important*** **,** please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$ 27,428	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 30,731	2
3. Under or (over) accrual (line 2 minus line 1).		$ 3,303	3
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 30,731	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 34,034	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2000	21,588	8
	2001	21,942	9
	2002	23,384	10
	2003	28,693	11
	2004	30,731	12

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2004	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions,

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Lawrence Community Healthcare Center, Inc COUNTY Lawrence

FACILITY IDPH LICENSE NUMBER 0045617

CONTACT PERSON REGARDING THIS REPORT John Knoblett, CPA

TELEPHONE (618) 943-3344 FAX #: (618) 943-2368

A. **Summary of Real Estate Tax Cos**

Enter the tax index number and real estate tax assessed for 2004 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 200

	(A) Tax Index Numbe	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	06-000-701-0A	Land and Building	$ 30,730.78	$ 30,730.78
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 30,730.78	$ 30,730.78

B. **Real Estate Tax Cost Allocation**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services? YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used

C. **Tax Bills**

Attach a copy of the original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 200 tax bill which is normally paid during 2005

Facility Name & ID Number Lawrence Community Healthcare Center, Inc. # 0045617 Report Period Beginning: 01/01/05 Ending: 12/31/05

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 23,766 B. General Construction Type: Exterior Brick Frame Brick Number of Stories 1

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred:
2. Number of Years Over Which it is Being Amortized:
3. Current Period Amortization:
4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	52,541	1996	$ 20,000	1
2					2
3	TOTALS	52,541		$ 20,000	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lawrence Community Healthcare Center, Inc. # 0045617 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	99		1996		$ 664,000	$ 16,600	40	$ 16,600	$	$ 157,700	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Siding			1997	5,300	133	40	133		1,127	9
10	Two four ton air conditioning units			1997	3,586	359	10	359		3,049	10
11	Fire alarm system			1998	17,000	1,133	15	1,133		9,066	11
12	Telephone system w/ call lights			1998	17,300	1,730	10	1,730		12,831	12
13	Concrete pads			1998	734	49	15	49		359	13
14	Awing at back door			1998	890	59	15	59		435	14
15	Wallpaper/painting			1998	2,444		5			2,444	15
16	Asphalt parking lot			1998	13,374	1,337	10	1,337		10,364	16
17	Landscaping / trees / shrubs			1998	2,906	291	10	291		2,204	17
18	Parking lot			1999	1,029	103	10	103		643	18
19	Flooring / tiling			1999	12,600	1,260	10	1,260		8,715	19
20	Carpentry work			1999	3,645	243	15	243		1,661	20
21	Bathroom renovation			1999	3,570	238	15	238		1,607	21
22	Hot water system			1999	10,500	700	15	700		4,725	22
23	Hand rails			1999	3,520	235	15	235		1,584	23
24	Wallpaper/painting			1999	3,142		5			3,142	24
25	Alarm system			2000	5,297	353	15	353		2,325	25
26	Replacement windows			2000	3,864	258	15	258		1,503	26
27	Water heater			2000	4,350	435	10	435		2,501	27
28	Flooring / tiling			2000	3,200	320	10	320		1,813	28
29	Plumbing			2000	1,719	86	20	86		480	29
30	Fire suppression system			2000	1,849	74	25	74		401	30
31	Flooring / tiling			2000	2,600	260	10	260		1,408	31
32	Flooring / tiling			2001	4,450	445	10	445		2,225	32
33	Flooring / tiling			2001	3,340	334	10	334		1,642	33
34	Flooring / tiling			2001	3,150	315	10	315		1,549	34
35	Flooring / tiling			2001	4,450	445	10	445		2,188	35
36	Flooring / tiling			2001	2,625	263	10	263		1,290	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Lawrence Community Healthcare Center, Inc. # 0045617 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Bi-fold doors	2001	$ 1,665	$ 166	10	$ 166	$	$ 791	37
38	120 gal water heater	2001	2,483	248	10	248		1,035	38
39	Water heater	2002	2,961	296	10	296		1,160	39
40	Tempature control valve	2002	980	98	10	98		384	40
41	Chandliers	2002	1,532	153	10	153		587	41
42	Windows	2002	1,900	190	10	190		618	42
43	Carpet	2003	3,378	338	10	338		816	43
44	Carpet	2003	1,570	157	10	157		157	44
45	Water softner	2003	2,103	210	10	210		438	45
46	Air conditioning units	2003	77,655	7,766	10	7,766		18,767	46
47	Sidewalk	2005	7,600	211	15	211		211	47
48	Storage barn	2005	3,390	169	15	169		169	48
49	Doors	2005	5,042	189	20	189		189	49
50	Painting	2005	10,455	349	10	349		349	50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 929,148	$ 38,598		$ 38,598	$	$ 266,652	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Lawrence Community Healthcare Center, Inc. # 0045617 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 518,262	$ 51,087	$ 51,087	$	5-15 yrs	$ 469,174	71
72	Current Year Purchases	9,501	728	728		10 yrs	728	72
73	Fully Depreciated Assets	26,928				5 yrs	26,928	73
74								74
75	TOTALS	$ 554,691	$ 51,815	$ 51,815	$		$ 496,830	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Transport patients	2000 Ford E-250HD Van	1999	$ 36,009	$	$	$		$ 36,009	76
77	Transport patients	2004 Toyota Sequoia	2004	48,550	9,710	9,710		5	12,947	77
78										78
79										79
80	TOTALS			$ 84,559	$ 9,710	$ 9,710	$		$ 48,956	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 1,588,398	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 100,123	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 100,123	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 812,438	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Lawrence Community Healthcare Center, Inc. # 0045617 Report Period Beginning: 01/01/05 Ending: 12/31/05

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? ☐ YES ☐ NO
   If NO, see instructions.

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
    Beginning
    Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2006	$
13.	/2007	$
14.	/2008	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: $ Description:
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lawrence Community Healthcare Center, Inc. # 0045617 Report Period Beginning: 01/01/05 Ending: 12/31/05

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lawrence Community Healthcare Center, Inc. # 0045617 Report Period Beginning: 01/01/05 Ending: 12/31/05

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service		Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10A-3	2192	hrs	$ 121,739		$	$	2,192	$ 121,739	1
2	Licensed Speech and Language Development Therapist	10A-3	1670	hrs	105,472				1,670	105,472	2
3	Licensed Recreational Therapist			hrs							3
4	Licensed Physical Therapist	10A-3	2804	hrs	129,433				2,804	129,433	4
5	Physician Care			visits							5
6	Dental Care			visits							6
7	Work Related Program			hrs							7
8	Habilitation			hrs							8
9	Pharmacy			# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)			hrs							10
11	Academic Education			hrs							11
12	Exceptional Care Program	39			198,225			29,284		227,509	12
13	Other (specify):										13
14	TOTAL				$ 554,869		$	$ 29,284	6,666	$ 584,153	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Facility Name & ID Number Lawrence Community Healthcare Center, Inc. # 0045617 **Report Period Beginning:** 01/01/05 **Ending:** 12/31/05

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/05 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 122,880	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	502,156		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	28,383		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	21,500		8
9	Other(specify): Employee advances	1,747		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 676,666	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	107,294		15
16	Equipment, at Historical Cost	639,250		16
17	Accumulated Depreciation (book methods)	(569,422)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 177,122	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 853,788	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 151,133	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	68,252		30
31	Accrued Taxes Payable (excluding real estate taxes)	4,171		31
32	Accrued Real Estate Taxes(Sch.IX-B)	30,731		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Insurance	18,585		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 272,872	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	14,061		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Advances from Owners	511,113		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 525,174	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 798,046	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 55,742	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 853,788	$	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Lawrence Community Healthcare Center, Inc. # 0045617 Report Period Beginning: 01/01/05 Ending: 12/31/05

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 69,107	1
2	Restatements (describe):		2
3	**Forgiveness of Accrued Rent**	24,249	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 93,356	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	482,386	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(520,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (37,614)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 55,742	24 *

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lawrence Community Healthcare Center, Inc. # 0045617 Report Period Beginning: 01/01/05 Ending: 12/31/05

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,771,236	1
2	Discounts and Allowances for all Levels	(683,439)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,087,797	3
	B. Ancillary Revenue		
4	Day Care	3,760	4
5	Other Care for Outpatients		5
6	Therapy	714,447	6
7	Oxygen	96,938	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 815,145	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	7,847	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	117,417	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	19,807	19
20	Radiology and X-Ray	9,669	20
21	Other Medical Services	48,680	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 203,420	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	2,337	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 2,337	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous	140	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 140	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,108,839	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	746,887	31
32	Health Care	1,643,127	32
33	General Administration	811,909	33
	B. Capital Expense		
34	Ownership	227,498	34
	C. Ancillary Expense		
35	Special Cost Centers	142,690	35
36	Provider Participation Fee	54,203	36
	D. Other Expenses (specify):		
37	Contributions	139	37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,626,453	40
41	**Income before Income Taxes (line 30 minus line 40)****	482,386	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 482,386	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return?** No **If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.** SEE ACCOUNTANTS' COMPILATION REPORT

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Lawrence Community Healthcare Center, Inc. # 0045617 Report Period Beginning: 01/01/05 Ending: 12/31/05

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,040	2,080	$ 51,231	$ 24.63	1
2	Assistant Director of Nursing	2,080	2,080	39,454	18.97	2
3	Registered Nurses	6,442	7,243	128,782	17.78	3
4	Licensed Practical Nurses	12,160	14,120	215,114	15.23	4
5	CNAs & Orderlies	75,506	73,852	625,212	8.47	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,016	2,064	19,468	9.43	9
10	Activity Assistants	5,394	5,644	41,087	7.28	10
11	Social Service Workers	3,604	3,751	36,394	9.70	11
12	Dietician					12
13	Food Service Supervisor	1,368	1,288	13,524	10.50	13
14	Head Cook	3,212	3,407	26,965	7.91	14
15	Cook Helpers/Assistants	11,229	13,319	102,665	7.71	15
16	Dishwashers	2,244	2,274	16,411	7.22	16
17	Maintenance Workers	3,650	3,818	37,875	9.92	17
18	Housekeepers	16,771	17,743	133,456	7.52	18
19	Laundry	3,316	3,668	29,104	7.93	19
20	Administrator	2,080	2,080	83,650	40.22	20
21	Assistant Administrator	1,216	1,240	22,589	18.22	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	2,032	2,072	20,448	9.87	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,714	1,849	16,665	9.01	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	158,074	163,592	$ 1,660,094 *	$ 10.15	34

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	123	$ 4,343	01-03	35
36	Medical Director	40	2,000	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	47	3,091	39-03	39
40	Physical Therapy Consultant	173	7,404	10-03	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	36	1,542	11-03	44
45	Social Service Consultant	36	1,542	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	455	$ 19,922		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		$		53

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

Facility Name & ID Number Lawrence Community Healthcare Center, Inc. # 0045617 Report Period Beginning: 01/01/05 Ending: 12/31/05

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Willliam R. Gillis	Administrator	20%	$ 83,650
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 83,650

B. Administrative - Other

Description	Amount
Replacement Tax	$ 1,669
Management fees	264,000
TOTAL (agree to Schedule V, line 17, col. 3)	$ 265,669
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Kemper CPA Group LLP	Accounting	$ 14,575
Stout & Holtzhouser	Legal	200
Kemper Technology	Computer services	3,182
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 17,957

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 57,253
Unemployment Compensation Insurance	21,529
FICA Taxes	133,212
Employee Health Insurance	32,785
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
TOTAL (agree to Schedule V, line 22, col.8)	$ 244,779

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	7,562
Health Care Worker Background Check	
(Indicate # of checks performed 46)	736
License fees	264
Dues and subscriptions	1,061
Less: Public Relations Expense	( )
Non-allowable advertising	(25)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 9,598

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Program transportation - gas, oil, etc.	9,972
Employee mileage reimbursements	9,495
Lodging	1,919
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 21,386

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lawrence Community Healthcare Center, Inc. # 0045617 Report Period Beginning: 01/01/05 Ending: 12/31/05

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lawrence Community Healthcare Center, Inc. # 0045617 Report Period Beginning: 01/01/05 Ending: 12/31/05

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **No**
If YES, give association name and amount.

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **0** Line

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **54,203**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **No** Indicate the amount. $ **0**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **100%**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **0**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.

Adjustments, line 29	Amount	Line
Vending machine revenue	0.00	21
Miscellaneous income	(140.00)	21
	(140.00)	

Page 4, line 43 detail

	Column 3	Column 5	Total
Contributions	139	1,180	1,319
			1,319

Pg 15
There are no training fees because Lawrence Community only hires fully-trained employees.

SEE ACCOUNTANTS' COMPILATION REPORT.

Pg 8 - Allocation of costs of Related Party - Rincker Healthcare, Inc.

Line Description	Amount	Line Ref
Administrative	54,350	17
Professional Services	2,045	19
Clerical & General Office Expenses	86,402	21
Employee Benefits & Payroll Taxes	14,833	22
Travel and Seminar	2,245	24
Insurance - Prop.Liab.Malpractice	470	26
Interest	1,765	32
Rent - Equipment & Vehicles	7,256	35
Donations	1,180	43
Administrative	170,546	17
Depreciation	28,682	30
Interest	54,456	32
Rent - Facility Grounds	83,138	34
Grand Total of allocated costs	253,684	

SEE ACCOUNTANTS' COMPILATION REPORT.

Reconciliation of taxable income to book net income

Book Net income	$	482,386
Difference book vs. tax depreciation		59,184
Disallowed Meals & Entertainment		3,625
Accrual to cash conversion		11,040
Taxable Income	$	556,235

SEE ACCOUNTANTS' COMPILATION REPORT.

Breakdown of owner salaries from other nursing homes

	William Rincker	Angie West	Deanna Gillis	Jane Rincker	Rob Gillis
Friendship Manor	6,361.00	6,361.00	6,361.00	37,103.00	8,905.00
West Grove	5,618.00	5,618.00	5,618.00	32,774.00	7,866.00
Lawrence Comm. Healthcare Center	11,661.00	11,661.00	11,661.00	68,021.00	99,975.00
Rincker Residential	6,360.00	6,360.00	6,360.00	37,102.00	8,904.00
	30,000.00	30,000.00	30,000.00	175,000.00	125,650.00
Salaries reported on this cost report	(11,661.00)	(11,661.00)	(11,661.00)	(68,021.00)	(99,975.00)
Salaries reported by other homes	18,339.00	18,339.00	18,339.00	106,979.00	25,675.00

SEE ACCOUNTANTS' COMPILATION REPORT.

Fixed Assets Reconciliation

	Land	Building & Improvements	Equipment	Vehicles	Total
Schedule XV Balance Sheet	$ -	$ 107,294	$ 554,691	$ 84,559	$ 746,544
Schedule XI Ownership Costs	20,000	929,148	554,691	84,559	1,588,398
Difference	$ (20,000)	$ (821,854)	$ -	$ -	$ (841,854)

On January 1, 2002, Lawrence Community Healthcare Center was incorporated. The real estate, building, and building improvements were not included. The facility is rented from a related party and the appropriate adjustments have been made on the cost report.

SEE ACCOUNTANTS' COMPILATION REPORT.

List of Related Parties (attachment to pg. 6)

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	**Ownership %**	**Name**	**City**	**Name**	**City**	**Type of Business**
Angela West Trust	25%	Friendship Manor of St. Elmo	St. Elmo			
Angela West Trust	25%	Rincker Healthcare Corporation	Bridgeport			
Angela West Trust	25%	West Grove, Inc.	Lawrenceville			
Mary Jane Rincker Trust	25%	Friendship Manor of St. Elmo	St. Elmo			
Mary Jane Rincker Trust	25%	Rincker Healthcare Corporation	Bridgeport			
Mary Jane Rincker Trust	25%	West Grove, Inc.	Lawrenceville			
Deanna Gillis Trust	25%	Friendship Manor of St. Elmo	St. Elmo			
Deanna Gillis Trust	25%	Rincker Healthcare Corporation	Bridgeport			
Deanna Gillis Trust	25%	West Grove, Inc.	Lawrenceville			
William J. Rincker Trust	25%	Friendship Manor of St. Elmo	St. Elmo			
William J. Rincker Trust	25%	Rincker Healthcare Corporation	Bridgeport			
William J. Rincker Trust	25%	West Grove, Inc.	Lawrenceville			

SEE ACCOUNTANT"S COMPILATION REPORT.